DOCUMENT RESUME

ED 435 059 CG 029 515

AUTHOR Silverman, Wade H.
TITLE Psychotherapy in the New Millennium.
PUB DATE 1999-08-00
NOTE 22p.; Presidents' Address presented at the Annual Convention of the American Psychological Association (107th, Boston, MA, August 20-24, 1999).
PUB TYPE Opinion Papers (120) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Counseling Psychology; *Counselor Client Relationship; Cultural Pluralism; Gerontology; Health Maintenance Organizations; Internet; Organizational Development; Organizational Effectiveness; Prediction; *Professional Development; Professional Training; *Psychotherapy; Sexual Identity; *Specialization; Speeches; Standards; Therapy
IDENTIFIERS Professional Concerns; *Professional Guidelines

ABSTRACT

This article reviews seven trends that were identified several years ago that have impacted the field of psychotherapy, especially such estimated changes as psycho-economics, managed care, wellness promotion, gender, and elderly care. Six new trends are described that are emerging and are leading the profession into the future: psychotherapy integration, specialization, managing psychotherapy, expansion of the scope of practice, cultural diversity, and psychotherapy without walls. Psychotherapy integration is described as finding the right therapist for the right problem. Through specialization, psychotherapists can offer a unique skill they have developed. How managed care reform continues to change the psychotherapy profession is discussed and the possibility of expanding the scope of practice through prescription drug privileges is examined. It is stated that in order for psychotherapists to survive in practice, they must address how to involve diversity in students coming into the practice and diversity among clients using their services. Psychotherapy without walls acknowledges the reality that future interactions between clients and therapists may be in "virtual" time. The conclusion indicates that the profession will be dealing with a revolutionary explosion of new forms and models for training, practice, and research. (Contains 53 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 435 059

Psychotherapy in the New Millennium.

Wade H. Silverman

Several years ago, I wrote an editorial piece in Psychotherapy identifying seven trends which were to impact upon the field of psychotherapy (Silverman, 1994). These included psycho-economics, the new client, gender and psychotherapy, psychotherapy and the elderly, drug therapy and psychotherapy, professional training at the doctoral level and beyond, and pragmatism. Before proceeding with my prognostications for the twenty-first century, let's examine my track record from several years ago as a preface for the future and as an exercise in humility.

The first trend that I identified was psycho-economics referring to mental health as big business. One of the consequences of this trend were new buzzwords such as cost effectiveness, accountability, and pre-authorization. We were moving toward briefer psychotherapy. Indeed, this has now been realized through the invasion of managed care into the majority of mental health markets. Another trend I identified was the increasing number of mental health dollars spent in inpatient settings. I stated that the misuse of hospitalization was a far more corrupting force than the possibility of prescription privileges. I am pleased to report that this trend toward more frequent use of inpatient settings has been reversed. Frank and Brookmeyer (1995) reported that the use of preadmission certification related to shortened hospital stays. Wickizer, Lessler, and Travis (1996) indicated that managed care utilization oversight reduced by two-thirds the number of hospital stays that were requested by providers.

CG029515

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
W. Silverman
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Finally, I referred to the discussion of cost effectiveness, citing a number of studies, particularly in the area of medical offsets showing how the cost of healthcare was reduced with brief psychotherapy. Unfortunately, these data have not yet been effectively communicated in the public sphere, in terms of promoting psychotherapy. Rather, we are now in an arena where we are debating "outcome" (Cummings, 1995). The topic of outcome in responding to managed care and accountability usually ends up in the trivialization of psychotherapy, e.g., treating specific symptoms for a specified period of time. In everyday practice, many of these symptoms are a consequence of situational factors such as the work environment or marital relationship. These complex factors are not so easily addressed through relaxation techniques or explaining to the client that he/she has irrational beliefs.

The second trend I identified was the new client. The new client was a product of the Self-Help movement of the 70's and 80's. This individual was described as interested in health promotion, as opposed to psychopathology or symptomotology. I am pleased to say our profession has responded effectively to this individual. We are now deeply involved in health enhancement and performance enhancement. As an example, a recent newsletter of the division of independent practice devoted an entire issue to mental health coaching. Professional psychologists are now working in the sports and business arenas promoting fitness and wellness. They are working with negative habits and developing positive ones in the arenas of drug abuse and weight management.

The next trend I identified was gender and psychotherapy. The field of psychotherapy has been quite successful in its effort to promote issues relating to gender to the general public. As an example, I was pleased to see William Pollack's book, Real Boys, on the New York Times Best

Sellers list (Pollack, 1998).

The next trend described was psychotherapy and the elderly. I noted that the elderly were the fastest growing population in the United States, and that we needed to increase our participation in both science and practice to meet the needs of this special client group. This journal with Norm Abeles as editor has recently published a special issue on psychology and aging (Abeles, 1998). To facilitate training in geropsychology, the Department of Veteran Affairs began funding post-doctoral fellowships in 1992 (Moye & Brown, 1995). There are at least ten sites currently in the VA with post-doctoral training programs in geropsychology. Though we are still not seeing this population relative to its proportion of the general population, we are finally emphasizing the elderly in our training and research efforts.

The next trend I identified was drug therapy and psychotherapy. I cautioned that there was more light than heat with regard to the issue of prescription privileges. We needed to "sort out the relevant efficacy of medication versus psychotherapy and medication." We now have some data to begin to do some evaluation, and are actively pursuing prescription privileges. This will be discussed in the next section.

The next trend to which I referred was professional training at the doctoral level and beyond. Preeminent issues that I identified were generalization versus specialization, the integration of applied psychology at the graduate level, the Psy.D. versus Ph.D. at the clinical level, the importance of board certification, future directions in APA accreditations, and the use of training manuals and psychotherapy supervision. This conflict between generalization and specialization will continue to be debated over the next several years and will be discussed later in the paper. As to the integration of applied psychology at the graduate level, it is beginning to

emerge in the arena of prescription privileges. Graduate and professional schools are beginning to develop model curriculum. As to the Ph.D. and Psy.D., the Accreditation Committee of the APA is working with psychology graduate programs to help them articulate their training models. From this cooperation, we will more clearly be able to delineate the processes of training for the Psy.D. and Ph.D. We will then be in position to look at the products of these respective types of programs and the unique contributions that each makes to the field.

Board certification continues to be a relatively neglected area in psychology. In a recent presentation to the Florida Psychology Association, during its Summer Meeting in 1999 President-Elect of the APA, Pat DeLeon emphasized the importance of Board Certification in enhancing the respect of psychology in the eyes of the public.

The final trend that I mentioned was pragmatism. I stated that psychotherapists were opting to use techniques based upon personal compatibility and utility as opposed to just theoretically determined. In this regard, Norcross (1996) notes, "with experience comes diversity, resourcefulness, and pluralism" (p. 130). Increasingly psychotherapists are integrating knowledge from a variety of theoretical orientations.

This will be elaborated upon in discussion of the first new trend in psychotherapy namely psychotherapy integration.

Having humbled myself before you in terms of my ability to predict the future, I will attempt to do so again, identifying six new trends in the field of psychotherapy. These include, psychotherapy integration, specialization, managing psychotherapy, expansion of the scope of practice, cultural diversity, and psychotherapy without walls.

Psychotherapy Integration

A decade ago Arnold Lazarus (1989) cautioned us that the level of theory of psychotherapy was not sophisticated enough for integration. In my editorial in 1994 I agreed with him. Times change as research is beginning to inform us about the exciting possibilities of psychotherapy integration. Keeping in mind the warning of Norcross (1995) to avoid the extremes of specific effects and common factors, I refer you to an article by Klaus Grawe (1997) which lays the foundation for a research informed psychotherapy. It is a model for psychotherapy integration based upon the question how does psychotherapy work. He outlined four mechanisms of change including 1) mastering/coping; 2) clarification of meaning; 3) problem activation; and 4) research activation. This brilliantly conceived model describes "a way of thinking about psychotherapy that goes beyond the traditional boundaries between therapy schools and therapy settings" (p. 17). He cautions that the empirically validated fad in psychotherapy may result in a better psychotherapy delivery system but not a better psychotherapy.

An example of "how does psychotherapy work" research comes from another of our colleagues Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) in which common and unique factors were examined in the use of cognitive behavioral therapy with depressed clients. Ironically these researchers found that variables common to other forms of therapy such as the clients' emotional experience and the therapeutic alliance were related to improvement, whereas the link between distorted thoughts and negative emotions, a unique focus of cognitive behavioral therapy, was related to depressive symptomotology. Indeed, changing cognitions in the interpersonal realm made global functioning worse (Hayes, Castonguay, & Goldfried, 1996).

In another study Raue, Castonguay, and Goldfried (1993), looked at working alliance ratings for two groups of experienced therapists, those who were psychodynamic-interpersonal in orientation, and those who were cognitive-behavioral in orientation. Total alliance scores were significantly higher for the latter than for the former. The authors speculate that these results may be due to therapeutic tasks and the severity of symptoms rather than the personal qualities of the therapist.

In a final example in this type of research, Goldfried, Raue, and Castonguay (1998) used a process system to ascertain differences between 22 master cognitive-behavioral and 14 master psychodynamic-interpersonal therapists. They were interested specifically in those sessions deemed significant by the therapists. There were many more process commonalities than between orientation differences. These included greater focus on clients ability to observe themselves in an objective manner, client evaluation of self-worth, and client expectation about the future. Therapists were also more likely to encourage clients to adapt more realistic views, to integrate thoughts and feelings into a larger theme, to provide factual information, and to indicate to clients the ways in which they were interfering with progress.

There is much to be learned about what are the active ingredients to psychotherapy. Simply studying specific techniques as they relate to symptom reduction fails to take into account the participants - therapist and client. This is absurd at its face and the reason why I have been so critical of the empirically validated movement (Silverman 1996, in press). Future research will focus on core ingredients such as the therapeutic alliance (Horvath & Greenberg, 1994) and expectancies (Silverman & Beech, 1979). These will also be more sophisticated "matching" studies such as in the work of Beutler and his colleagues (Beutler et al., 1991). We

will begin to formulate conceptions of the right therapist for the right client in the right context as opposed to the right technique for the right problem.

Specialization: Our Own Identity Crisis

In his recent book on marketing psychotherapy, Kal Heller (1997) recommends that in the competitive market of psychotherapy you should find a niche. That is, you should offer a special or unique service(s) in which you are skilled. The field of psychotherapy is highly competitive in a market of decreased governmental and insurance dollars and a geometrically increasing number of service providers. One of the adaptations to the overpopulated and underfunded psychotherapy market is specialization (see also Forman & Silverman, 1998). This will occur both in training and in the practice of psychotherapy.

In the training arena there is a proliferation of specialty programs at all levels. In response to the growing number of post-doctoral specialty programs, the APA Committee on Accreditation (CoA) has taken on the task of reviewing post-doctoral specialty programs. They received their first request for accreditation in January of 1997, and approved it in October of 1997. The CoA is now even receiving requests to review specialty training at the graduate level.

The APA has responded to the trend toward specialization with the formation of the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) established in 1995. This body reviews petitions requesting APA recognition for a specialty or proficiency. A specialty is defined as a field which requires comprehensive training e.g. clinical psychology, health psychology. The definition of a proficiency is more circumscribed requiring a series of course work or seminars such as would be involved in

biofeedback and hypnosis.

There will continue to be debates about the need for specialization in such a young science. There are dangers involved in the movement toward specialization. One danger is the potential inclusion of generalists to major shares of the market. We must be careful to be inclusive so as not to deprive our colleagues of the ability to make a living. This will require the accessibility to and availability of training in new areas of expertise and proficiency. Well designed and executed continuing education programs will be of increasing importance to the established clinician. We must also invite our colleagues to consider board certification. I agree with President DeLeon that the public appreciates and respects these credentials as do other professionals who are referral sources such as physicians and lawyers.

There is also potential danger of specialization in the training arena. As competition between training programs for students increases, more programs will begin to offer either specialty tracks or simply define themselves as a specialty program. We must be careful not to sacrifice sound, comprehensive general curricula for flashy "fadish" specialization tracks.

Managing Psychotherapy

Many psychotherapists are losing their autonomy in clinical decision-making and economic stability with the expansion of managed care. While I agree and sympathize with most of the criticisms delineated by Shore (1998), and others including Shapiro (1995), I agree with Cummings (1995) that managed care is the dominant economic force in health care delivery and will continue to be so for many years.

Though we may disdain the corporate mentality as applied to mental health services, we cannot simply dismiss managed care as a form of evil to be avoided at all costs. While I respect my colleagues who are in defiance of managed care, it must be noted that it is widely accepted by the public and by mental health service providers. Approximately 125 million Americans are enrolled in managed care (Strom-Gottfried, 1998). And in a recent survey by Norcross, Orlinsky and Beutler (1999) 60% of a sample of Division 29 members have accepted managed care patients for more than a year and 30% said that they would not accept managed care patients.

Some of the more egregious sins of managed care will be rectified not only because of public clamor, but because it is cost effective to the corporate entities. Remember the E. L. Phillips curve (Phillips, 1985). Most clients in most settings terminate after six sessions. In some public settings more than 50% drop-out after one session. Since there is a dramatic drop off in the number of clients continuing treatment after just a few sessions, it is cost effective to reduce drastically the amount of paper work presently required for the intake of managed care clients. Much of the burden will be removed. Similarly, the authorization process will also be streamlined to reduce management costs, while more emphasis will be placed on utilization review.

Though managed care has been widely accepted by the public, certain aspects of it are not acceptable. The public is demanding the right to due process of their grievances and the right to sue for mismanagement, negligence, and fraud. They also want the right to better access to specialists and to the right to choose their own practitioner. These changes will occur. California has already passed a set of bills that give patients the right to sue their HMO for punitive damages and to solicit outside reviews of decisions denying coverage. The legislature also

requires that the HMO pay for second opinions on some treatments. The legislature also required HMOS's to cover the testing and treatment of breast cancer, subsidize contraceptives and expand coverage for serious mental illness. At the federal level, Representative Norwood's bill for managed care reform currently before congress is one example of the climate for change. If passed it will fortify grievance procedures and establish the right to sue these entities.

Morris (1995) has listed a number of other reforms which will eventually occur including statutory regulation of conflict of interest situations in managed care, annual performance audits, quality assurance measures for selection and maintenance of providers, and the use of doctoral-level mental health professionals as opposed to primary care physicians and nurse specialists or even Bachelor's level workers as gatekeepers.

The future of independent practice will rely upon a variety of forms including practitioners working for or contracting with managed care entities, models of independent practice such as those described by Pipal (1996), and Kovacs (1991), and privately owned and operated professional groups.

Cummings (1995) of course is the pioneer of the independently operated managed care system. Systems owned and operated by psychologists will increase in number. One such entity is described by Berkman, Bassos, and Post (1988). The Synton group out of Lansing, Michigan, was developed over a decade ago by psychologists. It uses psychologists as managers and clinical coordinators for all of its managed care contracts. One of the valuable aspects of a system operated by psychologists is the design of an evaluative component. Through their evaluation of the service delivery system, the Synton group has documented the unique contributions of doctoral-level psychologists. As an example, they found that doctoral-level psychologists use

less sessions than master's-level providers, and they had a 7% drop out rate compared to 18% for master's-level providers (Howard, 1998). Similarly, Howard (in press) also found that Ph.D. psychologists with specialized training in the treatment of anxiety disorders were over twice as effective as a group consisting of 50% psychologists and 50% master's-level therapists and non-specialists trained in the treatment of anxiety disorders. Following a two year period, 18.6% of the patients treated by doctoral-level specialists returned for treatment while 39.7% of those treated by non-specialists returned for treatment.

Expanding the Scope of Practice: Prescription Privileges

I read an article recently by Adams and Bieliauskas (1994) called "On Perhaps Becoming What You Had Previously Despised: Psychologists as Prescribers of Medication." What I "despise" is arrogant, preachy moralists who tell them how to conduct their professional practices. A lot of the arguments against prescription privileges are similar to the Reverend Falwell talking about non-Christians. They are self-righteous and condescending. As an example, in reference to Norpramin the above authors ask, "how many psychologists are generally concerned for this drug's potential for interaction with alcohol, sedative-hypnotics, or other CNS depressants" (p. 92)? Who, but a poor person for a malpractice suit would not check on his or her clients use of medication with alcohol! The volume of some of the anti-prescriptive authority arguments get a little bit too loud. As an example, Hayes and Heiby (1996) call the movement for prescription privileges "psychology's drug problem."

In 1996 the APA Council of Representatives formally endorsed model legislation and curriculum for prescriptive authority (Cullen & Newman, 1997). This was the trumpet call for a

rising tide of professional and economic forces that will eventuate in prescriptive authority for psychologists. As we mature and become more confident as a profession we choose to be more in charge of our clients' well-being. We prefer not to farm them out to strangers who barely see them 15 minutes when medication is required. This is particularly true with such clinical populations as schizophrenics and manic depressives.

In a recent survey of directors of training and pre-doctoral interns (Ax, Forbes, & Thompson, 1997) an overwhelming 72% of both of these groups were in favor of prescription privileges. We will listen to our future professionals. Since the signing by President Bush in 1990 of PL101-165 three iterations of the military psychopharmacology program have been completed (Gutierrez & Silk, 1998). Curriculum are now being developed and implemented in a variety of sights including Nova Southeastern University, University of Georgia, and eight different state psychological associations. Some would argued that the introduction of prescription privileges to our practice would cause us to abandon our traditions (Moyer, 1995). Yet it is those very traditions that are being threatened by surrendering our ability to manage our own fate and the fate of our clients.

Cultural Diversity

Approximately one third of our population is comprised of cultural minorities (Highlen, 1994). In order for the practice of psychotherapy to survive we must address these individuals in terms of recruitment into our ranks and utilization of our services. President Suinn has made cultural diversity one of his initiatives during 1999, and, in Division 29 we are addressing this issue through the establishment of a task force which currently has several projects underway

including recruitment of minority students and psychological interventions with minority families with incarcerated members.

Addressing cultural diversity requires focused effort on delineating the needs of ethnic minorities. There are four primary reference groups: Native Americans, African Americans, Asian Americans, and Hispanic Americans-Latinos (Yutrzenka, 1995).

The APA Committee on Accreditation (1996) is a significant force in fomenting changes in graduate programs and internships to emphasize the importance of training future psychologists in cultural diversity (1996). Cultural diversity is one of the eight domains that provide the framework for assessing graduate programs and internships for accreditation. Compliance with this domain necessitates program recognition of the importance of cultural diversity training through evidence of "systematic, coherent, and long-term efforts to attract, and retain students and faculty" and "a thoughtful and coherent plan to provide students with relevant knowledge and experiences" (p. 9).

There is a rich variety of resources already available to enhance training in cultural diversity (see Stricker et al., 1990; Sue, 1991; Watts, 1992) that will help to foster culturally sensitive clinicians.

Two informative sources are provided by Davis-Russell and Troy. There are two major points of departure for providing training in cultural diversity. Davis-Russell (1990) proposes a strategy for minimum competencies for clinical psychologists. She offers four different models. The separate-course model calls for an additional course to the existing curriculum. The area of concentration model calls for a series of courses leading to a more in-depth study. The interdisciplinary model calls for students to take courses outside of their department. The

integration model calls for the inclusion of diversity topics within and across the entire curriculum.

An alternative proposal is presented by Troy (1990) who advocates more of a universal approach. First, he envisions professional training as emphasizing a set of competencies. These competencies are comprised of components of knowledge, attitudes, and skills as opposed to purely content areas. An integral part of the competency building is the notion that ethnic and cultural influences must pervade the entire curriculum. Another basic competency is the early exposure of all graduate students to faculty mentors who emphasize the importance of diversity in competency training.

Clinical research lags far behind training in addressing cultural diversity. As an example, in a recent article (Silverman, 1996) I vigorously criticized a Division 12 task force report on effective psychotherapies a.k.a. empirically validated therapies as "espousing empirically validated treatments for White people" (p. 214). It's insensitivity to the issues of cultural diversity in the formation of generalities as to whom to deliver what services were astounding.

Watts (1992) notes four perspectives that can contribute to a psychology of human diversity. These include a) population specific-psychologies such as the psychology of women or Asian-Americans; b) sociopolitical perspectives which expunge historical, economic, and system analysis; c) cross-cultural psychology; and d) ecological psychology. He identifies how each of these perspectives facilitate theory and action.

While research in diversity is in the embryonic stage. Yutrzenka (1995) does report that new cultural-inclusive theoretical models are being developed as well as more culturally sensitive and culturally-inclusive research designs and methodologies.

Psychotherapy Without Walls

In the age of modern technology with worldwide communication networks, there is increasing pressure for the field of psychotherapy to break free from the confined spaces of private offices with waiting rooms and white noise appliances and to enter the computer and telecommunications age. My generation of baby boomers are at home with the wide screen t.v. and remote control. The next generations are just as comfortable with the keyboard and mouse. Applied psychology is entering the age of tele-health "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education, and information across distance" (Nickelson, 1998, p. 527). Our tools are telephones, electronic-mail, and video teleconferencing equipment (Stamm, 1998)

Interactions between service provider and client may be in either "real-time" or "virtual." In real-time the client accesses the provider live through a telecommunication link-up most often in a hub and spoke system designed to include a broad geographical area (Nickelson, 1998). One interesting example of this is the California Smokers Help Line established in 1992 with similar programs in Massachusetts in 1994 and Michigan in 1996 (Zhu, Tedeschi, Anderson, & Pierce, 1996). Another is the use of video teleconferencing with acute psychiatric clinical interactions (McLaren, Blunden, Lipsedge, & Summerfield, 1996). Virtual interventions are highly controversial techniques because they involve "canned" or playback interventions stored and administered by technology. Psychologists have already used this technology in learning how to do psychotherapy (see Master Therapist series) and to diagnose through software designed decision trees available from testing services. A remarkable example of virtual intervention is a

study by Prochaska, DiClemente, Velicer, and Rossi (1993). The authors designed a computer-based decision-making system matching unique characteristics of the client with specific interventions. The knowledge used to design the system was the transtheoretical model for smoking cessation. This virtual intervention was more than twice as effective as one condition using manuals [25% versus 11%] and 45% better than a manual condition based upon it's own model [25.2% versus 18.5% in terms of point prevalence (1994) at 18 month follow up].

Obviously more research and considerably more thought must be put into the design and implementation of tele-health services. The APA has established a task force to consider the complex issues associated with remote interventions. Many of you will be accessing psychotherapy clients and coaching mentees in the not too distant future.

Summary

I have described six trends which will impact upon the theory, practice, research, and training in psychotherapy. They are psychotherapy integration, specialization, managing psychotherapy, prescription privileges, cultural diversity, and psychotherapy without walls. It is an exciting and dangerous time to be a psychotherapist. These adjectives are usually associated with a time of revolution. There will be a revolutionary explosion of new forms and new formats as well as new models for psychotherapy training, practice and research.

References

Abeles, N. (Ed.). (1998). Special issue: Psychotherapy and older adults. Psychotherapy: Theory/Research/Practice/Training, 35(4), 435-564.

Adams, K. M., & Bieliauskas, L. A. (1994). On perhaps becoming what you had previously despised: Psychologists as prescribers of medication. Journal of Clinical Psychology in Medical Settings, 1(3), 189-197.

APA Committee on Accreditation. (1996). Accreditation operating procedures of the committee on accreditation. Washington, D.C.: Author.

Ax, R. K., Forbes, M. R., & Thompson, D. D. (1997). Prescription privileges for psychologists: A survey of predoctoral interns and directors of training. Professional Psychology: Research and Practice, 28(6), 509-514.

Berkman, A. S., Bassos, C. A., & Post, L. (1988). Managed mental health care and independent practice: A challenge to psychology. Psychotherapy: Theory/Research/Practice/Training, 25(3), 434-440.

Beutler, L. E., Engle, D., Nohr, D., Daldrup, R. J., Bergan, J. Meredith, K., & Merry, W. (1991). Predictors of differential response to cognitive, experiential, and self-directed psychotherapeutic procedures. Journal of Consulting and Clinical Psychology, 59, 333-340.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. Journal of Consulting and Clinical Psychology, 64(3), 497-504.

Cullen, E. A., & Newman, R. (1997). In pursuit of prescription privileges. Professional Psychology: Research and Practice, 28(2), 101-106.

Cummings, N. A. (1995). Impact of managed care on employment and training: A primer for survival. Professional Psychology: Research and Practice, 26, 10-15.

Davis-Russell, E. (1990). Incorporating ethnic minority issues into the curriculum: Myths and realities. In G. Stricker, E. Davis-Russell, E. Bourg, E. Duran, W. R. Hammond, J. McHolland, K. Polite, & B. E. Vaughn (Eds.), Toward ethnic diversification in psychology education and training (pp. 171-178). Washington, DC: American Psychological Association.

Forman, B. D., & Silverman, W. H. (1998). Answers to the 50 most important questions about private mental health practice. Springfield, IL: Charles C. Thomas.

Frank, R. G., & Brookmeyer, R. (1995). Managed mental health care and patterns of inpatient utilization for treatment of affective disorders. Social Psychiatry and Psychiatric Epidemiology, 30, 220-223.

Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The Therapeutic Focus in Significant Sessions of Master Therapists: A Comparison of Cognitive-Behavioral and Psychodynamic-Interpersonal Interventions. Journal of Consulting and Clinical Psychology, 66(5), 803-810.

Grawe, K. (1997). Research-informed psychotherapy. Psychotherapy Research, 7, 1-19.

Gutierrez, P. M., & Silk, K. R. (1998). Prescription privileges for psychologists: A review of the psychological literature. Professional Psychology: Research and Practice, 29(3), 213-222.

Hayes, A. M., Castonguay, L. G., & Goldfried, M. R. (1996). Effectiveness of targeting the vulnerability factors of depression in cognitive therapy. Journal of Consulting and Clinical Psychology, 64(3), 623-627.

Hayes, S. C., & Heiby, E. (1996). Psychology's drug problem: Do we need a fix or should we just say no? American Psychologist, 51(3), 198-206.

Heller, K. (1997). Strategic marketing: How to achieve independence and prosperity in your mental health practice. Sarasota, FL: Professional Resource Press.

Highlen, P. S. (1994). Racial/ethnic diversity in doctoral programs of psychology: Challenges for the twenty-first century. Applied & Preventive Psychology, 3, 91-108.

Horvath, A. O., & Greenberg, L. S. (1994). The working alliance: Theory, research, practice. New York: John Wiley.

Howard, R. C. (1998). The sentinel effect in an outpatient managed care setting. Professional Psychology: Research and Practice, 29(3), 262-268.

Howard, R. C. (in press). Treatment of anxiety disorders: Does specialty training help? Professional Psychology: Research and Practice.

Kovacs, A. L. (1991). The uncertain future of professional psychology. Psychotherapy in Private Practice, 8, 39-60

Lazarus, A.A. (1989). Why I am an eclectic (not an integrationist). British Journal of Guidance and Counseling, 17, 248-258.

McLaren, P. M., Blunden, J., Lipsedge, M. L., & Summerfield, A. B. (1996).

Telepsychiatry in an inner-city community psychiatric service. Journal of Telemedicine and Telecare, 2, 57-59.

Morris, J. (1995, May/June). Psychologists will not survive by stubbornly rejecting 20 years of changes. The National Psychologist,15.

Moye, J., & Brown, E. (1995). Postdoctoral training in geropsychology: Guidelines for formal programs and continuing education. Professional Psychology: Research and Practice, 26(6), 591-597.

Moyer, D. M. (1995). An opposing view on prescription privileges for psychologists. Professional Psychology: Research and Practice, 26(6), 586-590.

Nickelson, D. W. (1998). Telehealth and the evolving health care system: Strategic opportunities for professional psychology. Professional Psychology: Research and Practice, 29(6), 527-535.

Norcross, J. C. (1995). Dispelling the dodo bird verdict and the exclusivity myth. Psychotherapy: Theory/Research/Practice/Training, 32(3), 500-504.

Norcross, J. C. (1996). The lifetime lessons of six psychologists: An introduction. Psychotherapy: Theory/Research/Practice/Training, 33, 129-130.

Norcross, J. C., Orlinsky, D., & Beutler, L. E. (1999). Managed care involvement and psychotherapy fees among APA division 29 members. Psychotherapy Bulletin 34(4).

Phillips, E. L. (1985). Psychotherapy revisited: New frontiers in research and practice. Hillsdale, NJ: Lawrence Erlbaum.

Pipal, J. E. (1996). Without apology or fear: Reflections on Hoyt and Budman (1996) and managed mental health care. Psychotherapy: Theory/Research/Practice/Training, 33, 124-128.

Pollack, W. S. (1998). Real boys: Rescuing our sons from the myths of boyhood. New York: Random House.

Prochaska, J. O., DiClemente, C. C., Velicer, W. F., & Rossie, J. S. (1993). Standardized, individualized, interactive, and personalized self-help programs for smoking cessation. Health Psychology, 12(5), 399-405.

Raue, P. J., Castonguay, L. G., & Goldfried, M. R. (1993). The working alliance: A comparison of two therapies. Psychotherapy Research, 3(3), 197-207.

Shapiro, J. (1995). The downside of managed mental health care. Clinical Social Work

Journal, 23(4), 441-451.

Shore, K. (1998). Managed care and managed competition: A question of morality. In R. F. Small (Ed.), Practicing in the new mental health marketplace: Ethical, legal, and moral issues (pp. 67-102). Washington, DC: APA.

Silverman, W. H. (1994). Major trends in psychotherapy: Implication for priorities for *Psychotherapy*. Psychotherapy: Theory/Research/Practice/Training, 31(2), 227-233.

Silverman, W. H. (1996). Cookbooks, manuals, and paint-by-numbers: Psychotherapy in the 90's. Psychotherapy: Theory/Research/Practice/Training, 33(2), 207-215.

Silverman, W. H. (in press). If it's Tuesday with depressive symptoms it must be cognitive-behavior therapy. Psychotherapy: Theory/Research/Practice/Training, 36(4).

Silverman, W. H., & Beech, R. (1979). Are dropouts, dropouts? Journal of Community Psychology, 7, 236-242.

Stamm, B. H. (1998). Clinical applications of telehealth in mental health care. Professional Psychology: Research and Practice, 29(6), 536-542.

Stricker, G, Davis-Russell, E., Bourg, E., Duran, E., Hammond, W. R., McHolland, J., Polite, K., & Vaughn, B. E. (Eds.). (1990). Toward ethnic diversification in psychology education and training. Washington, DC: APA.

Strom-Gottfried, K. (1998, May/June). Is "ethical managed care" an oxymoron? Families in Society: The Journal of Contemporary Human Services, 297-307.

Sue, D. W. (1991). A model for cultural diversity training. Journal of Counseling and Development, 70, 99-105.

Troy, W. G. (1990). Ethnic and cultural diversity and the professional psychology training curriculum. In G. Stricker, E. Davis-Russell, E. Bourg, E. Duran, W. R. Hammond, J. McHolland, K. Polite, & B. E. Vaughn (Eds.), Toward ethnic diversification in psychology education and training (pp. 179-190). Washington, DC: American Psychological Association.

Watts, R. J. (1992). Elements of a psychology of human diversity. Journal of Community Psychology, 20, 116-131.

Wickizer, T. M., Lessler, D., & Travis, K. M. (1996). Controlling inpatient psychiatric utilization through managed care. American Journal of Psychiatry, 153(3), 339-345.

Yutrzenka, B. A. (1995). Making a case for training in ethnic and cultural diversity in

increasing treatment efficacy. Journal of Consulting and Clinical Psychology, 63(2), 197-206.

Zhu, S., Tedeschi, G. J., Anderson, C. M., & Pierce, J. P. (1996). Telephone counseling for smoking cessation: What's in a call? Journal of Counseling & Development, 75, 93-101.